ONTARIO PSYCHIATRIC ASSOCIATION — 275 — P.O. hospitals — pte. practice —

BRIEF ON

MEDICAL CARE INSURANCE

TO THE

MEDICAL SERVICES INSURANCE ENQUIRY

Secretary:
Dr. W. H. Henderson,
Room 5321,
Department of Health,
Parliament Buildings,
Toronto 5, Ontario.

T O R O N T O
November 15th, 1963.

BRIEF ON

MEDICAL CARE INSURANCE

RECOMMENDATION 5

ACTIVE HOSPITAL TREATMENT FOR ACUTE PSYCHIATRIC ILLNESS SHOULD PROVIDE MEDICAL FEES FOR SPECIALISTS AS FOR ANY OTHER ILLNESS AND ACCORDING TO THE ONTARIO MEDICAL ASSOCIATION SCHEDULE. SERVICES MUST BE AVAILABLE ON MEDICAL ADVICE TO THE INDIVIDUAL PATIENT, WHEREVER TREATED. THE PRINCIPLE HERE IS THAT OF DESIGNATION OF PATIENTS OR ILLNESSES RATHER THAN LOCATIONS. THUS, WOULD BE INCLUDED HOSPITALS OPERATED UNDER THE MENTAL HOSPITALS ACT OF ONTARIO, THE PSYCHIATRIC HOSPITALS ACT OF ONTARIO, THE PRIVATE SANITARIA ACT, THE COMMUNITY PSYCHIATRIC HOSPITALS ACT, THE CHILDREN'S MENTAL HOSPITALS ACT, AS WELL AS THE PUBLIC HOSPITALS ACT.

RECOMMENDATION 6

CHRONIC HOSPITAL PSYCHIATRIC CARE SHOULD BE ON THE SAME BASIS AS ALL OTHER CARE AND INCLUDE HOSPITALS UNDER THE MENTAL HOSPITALS ACT OF ONTARIO, THE PSYCHIATRIC HOSPITALS ACT OF ONTARIO, THE PRIVATE SANITARIA ACT, THE COMMUNITY PSYCHIATRIC HOSPITALS ACT OF ONTARIO, THE CHILDREN'S MENTAL HOSPITALS ACT, AS WELL AS THE PUBLIC HOSPITALS ACT; AND SHOULD BE ACCORDING TO THE ONTARIO MEDICAL ASSOCIATION SCHEDULE.

RECOMMENDATION 7

IN GENERAL THE POLICY OF CO-INSURANCE FOR ALL MEDICAL CARE IS RECOMMENDED.

RECOMMENDATION 8

HOSPITALS DESIGNATED AS UNDERGRADUATE TEACHING HOSPITALS SHOULD BE GEOGRAPHICALLY DESIGNATED TEACHING UNITS WITH ADEQUATE FACILITIES, FULL TIME TEACHING MEMBERS ARRANGED IN SUCH A MANNER THAT THE TEACHING FACILITY DOES NOT BECOME SUBSERVIENT TO TREATMENT SERVICES, AND THAT THERE IS A GRADED RESPONSIBILITY FOR TEACHING STAFF FROM STUDENT TO RESIDENT AND AN ACCEPTABLE ARRANGEMENT MADE FOR THE POOLING AND DIVISION OF FEES.

RECOMMENDATION 9

PARAGRAPH 4 OF SCHEDULE A OF BILL 163 (1963), WHICH SPECIFIES EXCEPTIONS TO THE BILL AND WHICH NOW READS:

"MEDICAL, SURGICAL OR OBSTETRICAL SERVICES WHEN THE COVERED PERSON IS A PATIENT IN A SANATORIUM, INSTITUTION OR SPECIAL HOSPITAL FOR TUBERCULOSIS, MENTAL ILLNESS OR DIESASE, ALCOHOLISM, EPILEPSY, OR DRUG ADDICTION, WHERE SUCH SERVICES ARE PAID FOR BY THE SANATORIUM, INSTITUTION OR SPECIAL HOSPITAL."

BE AMENDED TO READ:

"MEDICAL, SURGICAL OR OBSTETRICAL SERVICES PROVIDED TO A COVERED PATIENT IN A HOSPITAL OR INSTITUTION WHEN THESE SERVICES ARE RENDERED BY A PHYSICIAN PAID A SALARY TO PROVIDE SUCH SERVICES."

SECTION B

PREAMBLE

1. The Ontario Psychiatric Association is an organization of physicians in the Province of Ontario who specialize in the care of patients with mental and emotional illnesses. The objectives of the Association are:

(a) to maintain an organization on behalf of the psychiatrists of Ontario for their mutual benefit, for the exchange of scientific information and for the promotion of their professional welfare and usefulness;

(b) to represent the members of the Association in their relationships with the Government of Ontario, municipal governments, universities, medical associations and other associations, organizations and bodies with which the psychiatrists of Ontario from time to time may have relationships;

(c) to publish journals and other literature for the dissemination of psychiatric knowledge;

(d) to affiliate with other organizations whose objects are similar to those of the Association;

(e) to receive bequests, donations, grants of money and to raise monies by membership fees, public subscription or in any other manner that is not contrary to the laws of Canada or Ontario for the carrying out of the objects of the Association.

It comprises some 275 physicians working in the mental hospitals of the Department of Health of the Province, in private practice, in private hospitals, Medical School teaching, with community clinics, schools and courts or engaged in research.

2. This Association endorses the principles embodied in Bill 163 in so far as they apply to prepayment of medical costs on a voluntary basis through multiple carriers and do not interfere with the relationship between patient and physician.

3. The Ontario Psychiatric Association wishes to draw the attention of the Medical Services Insurance Enquiry to certain aspects of Bill 163 in particular, and Medical Care Insurance in general, as it applies to psychiatric illness.

4. (a) Prior to World War II nearly all psychiatrists worked in Provincial Mental Hospitals as salaried employees of the Government. Since that time there has been a major change in the provision of psychiatric services in that an increasing number of psychiatrists have engaged in private practice centred around the general hospital. At the same time the Provincial Mental Hospital services have been expanded so that at the present time two systems of care and treatment of mental illness are operating in the Province.

(b) Organized medicine as represented by the Canadian Medical Association, Ontario Medical Association, Canadian Psychiatric Association, and the Ontario Psychiatric Association, and voluntary health groups such as the Canadian Mental Health Association have, after study, advocated that the mentally ill should be treated on the same basis as any other illness, financed in the same way, and that the practice of psychiatry should be reintegrated into the general practice of medicine.

(c) The admission of patients to mental hospitals under the care of private psychiatrists in practice in the local community, the admission of patients to mental hospitals without legal documentation, the transfer of administrative responsibility for mental health clinics from the Province to the community, the gradual extension of coverage for psychiatric care under some Medical Insurance schemes, and the rapid development of psychiatric services in general hospitals are all significant advances that have been made toward the goal of integrating treatment of mental illness into the general practice of medicine.

(d) It is recognized that the responsibility for further progress in the integration of the practice of psychiatry into general medicine does not rest solely with the carriers of medical care insurance. This can only be accomplished by the co-operative effort of public opinion, medical education, expansion of psychiatric facilities in general hospital, procurement of professional staff and the reorganization of financing of existing mental hospitals.

5. (a) For the first time a universal medical care insurance plan with specific benefits is to be enacted as law. It is the concern of the Ontario Psychiatric Association that this legislation in no way impede the slow but steady progress that has been and is being made in insurance coverage of psychiatric care. This Association

fears that a case may be advanced to freeze the present dichotomy in provision of care, and to preserve by legislation the two existing systems of financing psychiatric services. This would bring progress to a halt. Therefore, the Association opposes any limitation by this proposed Act or Regulation under this Act which would discriminate against the insurance of medical services according to the location of treatment or the diagnosis.

(b) While exception (4) in Schedule A of Bill 163 does not so state, the Association has reason to believe that some carriers feel that the exclusion of services in special hospitals for the treatment of mental illness implies the exclusion of all psychiatric illness from coverage. This interpretation would appear to be based on the opinion that all such illnesses are, could be, or should be treated in special centres. This is not the case nor is it desirable or practical. e.g. a person suffering a delirium after head injury or an acute postpartum depression usually can and should be treated on the spot and in a general hospital.

6 (a) One of the arguments advanced in favor of the spirit of Bill 163 is that it preserves the values of free choice of doctor and the doctor-patient relationship with all that this implies for good medical care. This argument certainly applies with at least equal force to the psychiatric patient and his treating physician where the

relationship is fundamental. Past denial to many psychiatric patients of the benefits of this personal doctor-patient relationship is no reason for perpetuating the defect when a remedy is possible.

(b) Patients who can afford care from a private practitioner in his office or general hospital now tend to choose this way. As more people are able to afford such care and as it becomes more available, they will tend to select it. This rapidly developing trend could have a serious effect on the staffing of Provincial Mental Health Services. This could be corrected by an accommodation of the Provincial Mental Health Services to this emerging pattern with the desired result that the mental hospitals would become psychiatric treatment centres on a similar basis as any other community or general hospital psychiatric unit.

7. Carriers are concerned with lack of experience upon which to base the cost of coverage of psychiatric illness. The Association contends that the estimates presented below could not be exceeded for the next few years and that that a premium structure based on present available information would, in fact, provide a "cushion" since the developments looked for would not take place suddenly. During the next five years the claims pattern would become clearer and the premium rates adjusted at the end of that time on the basis of claims experienced during that period.

SECTION C

DISCUSSION

RECOMMENDATION 1

All prepaid medical insurance plans should cover mental illness on the same basis as any other illness.

The above recommendation is the stated policy of the organized medical profession in Canada, including the Canadian Medical Association, the Ontario Medical Association, the Canadian Psychiatric Association and the Ontario Psychiatric Association. It is also the stated policy of the Canadian Mental Health Association in its brief to the Royal Commission (1962).

This axiom was accepted by the Committee as the basis of the establishing policy and no further justification is made herein.

RECOMMENDATION 2

All medical care should commence with the family practitioner who, when it becomes advisable, would refer his patient to other physicians. It therefore follows that the family practitioner is to be reimbursed for diagnosis and for treatment of psychiatric disorder including psychotherapy according to the general tariff of the Ontario Medical Association.

The Committee strongly supports this recommendation because, historically, the family practitioner has been the corner-stone of medical care and, because of his close relation with the family and the patient, practised excellent psychotherapy. Subsequent developments have tended to exclude the practitioner and the benefit of this factor has been lost to the patient. This

recommendation produces tremendous pressure to restore the practitioner to his proper place in the care of the patient. Moreover, recently the general practitioner has been better equipped by training to readopt this responsibility and this recommendation will provide the encouragement of remuneration.

RECOMMENDATION 3

In or out of hospital, consultation with report to referring physician, wherever provided by a psychiatrist, should be covered on the same basis as any other specialist consultation, with the exception of:

Examination required for the administration of justice

AND

Consultations with the staff of social, educational, vocational, and other agencies where direct patient care is not involved,

AND

Other situations not covered by medical care insurance.

ALTERNATIVES AND PRESENT COVERAGE

There seemed little in the way of alternatives to this proposal, since even policies which exclude psychiatric treatment from coverage make provision for determining if a psychiatric condition exists.

PROBLEMS

No special problems are foreseen provided the general rules governing referral in general, defined by the O.M.A. are followed. "Self referral" would be permissible on the same terms as apply in general, e.g. at general tariff rates on

some policies. Costs of diagnostic services by ancillary psychiatric personnel should be dealt with the same as commensurate personnel in any other specialty.

COSTS

The rate of psychiatric consultation should be easily calculable by those carriers who record consultation by specialty. The overall per annum in Ontario is calculated from a number of estimates at 7.5 psychiatric consultations per 1,000 population per annum for a total cost of approximately one million dollars. Confirmation of this figure was found in the Worthing experiment in England which established the consultation rate in that community at eight per thousand per annum.

RECOMMENDATION 4

For out of hospital treatment, psychiatric care should be covered according to the Ontario Medical Association schedule. Psychotherapy should be limited to the cost of the equivalent of fifty hours per annum.

ALTERNATIVES AND PRESENT COVERAGE

No serious alternatives to some provision for insurance coverage of psychiatric care in the community were considered. While there are wholly tax supported mental health clinics in operation, these represent only a fraction of the total out-patient services, including office private, and are unable to provide the basic treatment required. Some objections that could be raised to an extension are mentioned under problems below.

In Ontario at present, plans available range from no coverage for treatment through coverage at G.P. rates to unlimited coverage at 90% O.M.A. schedule (Public Service Plan). Other provinces have plans with dollar or maximum visit limitation, i.e. B.C. medical plan.

PROBLEMS

It was in this area that most of the concern regarding the effect of insurance on therapy was voiced. There are several plans which sharply limit psychiatric care, which cover a large majority of patients at present. One problem is that those requiring more extended care are in a sense those most catastrophically involved and in need of insurance protection. On the other hand, responsible experienced psychotherapists are deeply concerned with the place of realistic involvement by the patient in the sacrifice needed for certain forms of therapy. A survey has been conducted of the Section on Psychotherapy, of the Ontario Psychiatric Association, as to the members' ideas on this matter. A broad spectrum of opinion was revealed, the report ranging from no possibility of covering psychotherapy on the one hand to full coverage on the other with intermediate opinions of co-insurance, deterrents and dollar limits.

The restriction limiting psychotherapy to those sufficiently disabled to be absent from work was considered unsatisfactory by both the carriers representatives and the Committee. Another alternative which was proposed by the Canadian Health Insurance Association in their brief to the Royal Commission (1962) was for a co-insurance out-patient

psychotherapy of fifty percent. This figure is derived from the psychiatric advisers to American insurance companies and does not conform to Canadian requirements.

The Committee accepted the view that psychoanalysis or intensive long term re-constructive psychotherapy, on the basis of three or more sessions a week for a number of years, could not be fully covered. On the other hand, it was not fully possible to classify patients in the first stages of psychotherapy and decide whether or not they were going to require this length of therapy or determine initially who would and who would not have to pay a specific portion of the fee themselves. We recommended a limit to the equivalent of fifty hours of psychotherapy per annum which covers treatment of illnesses and provides the partial participation by patients advised in more long term intensive treatment by both insurance carriers and psychotherapists.

COSTS

Based on the experience of the Public Service of Canada, and the indemnity Benefit Plan of the American Civil Service, the carriers report somewhere between 1.7 and 2.5% for out of hospital psychiatric care. The nearest approximation of total cost for the people of Ontario, based on 2% of the total medical costs calculated at $250,000,000.00 per annum would represent $5,000,000.00 for out of hospital psychiatric treatment.

RECOMMENDATION 5

Active hospital treatment for acute psychiatric illness should provide medical fees for specialists as for any other illness and according to the Ontario Medical Association schedule. Services must be available on medical advice to the individual patient, wherever treated. The principle here is that of designation of patients or illnesses rather than locations. Thus would be included hospitals operated under the Mental Hospitals Act of Ontario, The Psychiatric Hospitals Act of Ontario, The Private Sanitaria Act, The Community Psychiatric Hospitals Act, The Children's Mental Hospitals Act, as well as The Public Hospitals Act.

PRESENT COVERAGE

Most commercial carriers and P.S.I. cover psychiatric care in general hospitals on the same basis, without time limitation, and according to Ontario Medical Association tariff as for other medical diseases. None covers medical costs in Ontario Hospitals with the exception of informal or open units. Private mental hospitals are covered in some few plans to a limited extent.

ALTERNATIVE

An alternative to our principle is to exclude from coverage the medical care costs in Ontario Hospitals. Such exclusion is inequitable since decision as to hospitalization site is often a matter of geography, thereby a policy holder living in one community would go into a hospital wherein he is covered, and in the next town the available facility is an Ontario Hospital, where he is not. Moreover, it continues the disparity between the mentally ill patient and other patients.

Forcing some patients to leave their attending physician for a period of hospitalization in an Ontario Hospital is detrimental to good care, or delays care while patient awaits a bed in a psychiatric ward of a general hospital often in a distant community. The patient also suffers discontinuity of care on discharge from Ontario Hospitals where he has been under a salaried clinician.

It seemed to the Committee that there is no excuse or valid reason for giving medical care insurance to psychiatric patients in hospital in any other way and that, in addition, such a plan ensures a much more economic use of the psychiatric services already available and offers increased facilities to the increasing number of people requiring psychiatric care by reason of expanding population, if for no other.

PROBLEMS

Anticipated in this proposal is the capability of mental hospitals to:

a. designate patient as:

   i. Acutely ill requiring intensive care.

   ii. Convalescent requiring continuing therapeutic care.

   iii. Chronically ill, mentally or physically.

   iv. In need of domicillary care only.

b. Organize their medical staffs in such a way as to permit supervision of clinical practice in terms of adequate medical by-laws. The Canadian Council on Hospital Accreditation now requires such an arrangement for the accreditation of mental hospitals.

It is foreseen by the Committee that only psychiatrists engaged in clinical work would receive a fee for service. Administrative or research physicians, and residents or house staff should be excluded from insurance coverage. The salaries of these latter physicians would be chargeable to hospital operating expenses. Where a clinical psychiatrist, in addition, adopts part time organization and/or administrative duties in connection with ward service, remuneration for this should be chargeable to hospital operating expenses.

Given these conditions there would be a period of transition when some more senior clinicians would wish to remain in a salaried service while others would be on a fee for service basis. In the situation while there was a shortage of practicing psychiatrists, strict control of the appropriate care of patients would have to be exercised by the chief of staff. Some more isolated hospitals might have to offer a closed group clinic arrangement to ensure stable hospital staffing.

The Committee recognizes these difficulties but considers them transitory and soluble. Moreover, such a division between medical care and hospital operating costs and the designation of patients into treatment categories would, in addition, make mental hospital financing through O.H.S.C. more feasible.

COSTS

Medical costs of psychiatric patients in general hospital based on Ontario Medical Association rates for 18,000 patients in 1961, for an average of 19 days stay, totals $1,500,000.00. Medical costs for acute services in Ontario Hospitals based on current figures would be $3,000,000.00. This is based on staffing at American Psychiatric Association standards or on the basis of number of acute patients treated per annum in Ontario Hospitals.

RECOMMENDATION 6

Chronic hospital psychiatric care should be on the same basis as all other care and include hospitals under The Mental Hospitals Act of Ontario, The Psychiatric Hospitals Act of Ontario, The Private Sanitaria Act, The Community Psychiatric Hospitals Act of Ontario, The Children's Mental Hospitals Act, as well as The Public Hospitals Act; and should be according to the Ontario Medical Association schedule.

PRESENT COVERAGE AND ALTERNATIVES

No insurance carriers, so far as we know, cover chronic care of psychiatric patients, so designated in Ontario Hospitals. However, some general practitioners and psychiatrists continue to care for patients in chronic disease hospitals who are covered under some plans.

There is the possibility that some alternative to fee for service may be accepted by the Ontario Medical Association for chronic hospital care in general. On one hand there is an argument in favor of a salaried or sessional fee to the clinician to daily supervise patients in chronic care

hospital, particularly in the provision of suitable ward milieu. On the other hand, the fact that the chronically ill, even more than the acutely ill, require the continuing care of their individual personal physician was emphasized by the consultants to the committee. However, failing this we can see no need for distinction between chronic physical care and chronic care of psychiatric patients, particularly when the latter suffer in a high proportion of cases with crippling physical disorder in addition. We feel that both these aspects of medical care require consideration and possibly the first need would be chargeable against the hospital operating budget and the second against medical care insurance.

PROBLEMS

The problems here are those of chronic care in general, particularly the physician's part in preventing further incapacity by tertiary prevention. Thus psychiatric care, as in physical illness, often means working through nursing and rehabilitation therapists.

It was accepted that, in general, continued treatment leaves a good deal to be desired in view of the shortage of staff, the increasing number of admissions annually, and the fairly large number of people requiring continued treatment. It is put forward that any plan of medical care insurance should attempt to see that this area of psychiatric treatment is provided for much more thoroughly. The present experience of certain members of the Committee would seem to indicate that less than half of the total beds given

over to the psychiatric care in the Province are devoted to this kind of continued treatment and that a very small percentage of the time of medical staff is available for this care.

COSTS

Bringing chronic and continuing treatment care to a satisfactory level would cost roughly $150.00-$180.00 per patient per year or somewhere in the region of two million dollars per annum for the province.

RECOMMENDATION 7

In general the policy of co-insurance for all medical care is recommended.

There are several reasons for this recommendation, e.g. no one is sure of the exact costs of medical care insurance and if the principle of co-insurance is included, costs will be kept down and coverage may be extended as experience dictates. This Committee is in agreement with the announced principles of organized medicine in Ontario that co-insurance should be considered to have a place in any medical care insurance programme but recognizes that in a free society the rights of individuals to purchase first dollar coverage are likely to be decisive.

RECOMMENDATION 8

Hospitals designated as undergraduate teaching hospitals should be geographically designated teaching units with adequate facilities, full time teaching members arranged in such a manner that the teaching facility does not become subservient to treatment services, and that there is a graded responsibility for teaching staff from

student to resident and an acceptable arrangement made for the pooling and division of fees.

It is presumed that adequate arrangements will be made to safeguard undergraduate teaching in general and that some type of closed group practice will be arranged in conformity with the above recommendation. It would appear that if the above principles are adhered to, no special problems for under-graduate psychiatric teaching are foreseen.

RECOMMENDATION 9

Paragraph 4 of Schedule A of Bill 163 (1963), which specifies exceptions to the bill and which now reads:

"Medical, surgical or obstetrical services when the covered person is a patient in a sanatorium, institution or special hospital for tuberculosis, mental illness or disease, alcoholism, epilepsy, or drug addiction, where such services are paid for by the sanatorium, institution or special hospital"

BE AMENDED TO READ:

"Medical, surgical or obstetrical services provided to a covered patient in a hospital or institution when these services are rendered by a physician paid a salary to provide such services".

It is presumably not the intention of the framers of this bill that any physician salaried to provide clinical care in any type of hospital would be eligible to be paid twice for the same service via the medical services insurance. It therefore does not seem necessary to specify a certain group of hospitals to which this would apply.

Covered under the present Bill 163 are services which would cost insurers more than half of the total medical care cost of psychiatric illness. The balance of these medical care costs, at the present time, would be met from general tax funds. However, the way the bill is presently worded there are alternative facilities, one fee supported and one tax supported. It will be possible for people to elect one or other type of facility and insurers will have no idea of the cost of this component of the population at risk.

COSTS:

It would seem wiser to plan to cover all aspects of psychiatric care, from the start, based upon the nearest estimates possible.

ESTIMATE OF TOTAL COSTS PER YEAR

Consultation	$1,000,000
Ambulatory	5,000,000
Acute Hospital Treatment	4,500,000
Chronic Hospital Care	2,000,000
	$12,500,000

A premium of $2.00 per annum per person in Ontario would cover these costs.

Another way of arriving at this figure is based on the estimate that there should be one psychiatrist per ten thousand population. Two dollars per person per annum would yield an average income of about $20,000 for each psychiatrist.

On this basis the requirement for the Province of Ontario would be 650 qualified clinical psychiatrists or about twice the present number.

REFERENCES

1. Avnet, H. H. - Psychiatric Insurance
Group Health Insurance, Inc.
221 Park Avenue South,
NEW YORK 3, New York.

2. Myers, J. Martin - Doctor-Patient Relationship
Canadian Psychiatric Association Journal.
Volume 8, No. 1, Feb. 1963.

3. McKerracher, D. G. - Modern Psychiatry and the Health Plans
New England Journal of Medicine, 260: 474. March 5, 1959.

- Psychiatry in General Practice
The Canadian Medical Association Journal,
Vol. 88, No. 20, 1963.

4. A. Richman and T. Bezeredi - Health Insurance Prepayment for Psychotherapy in Private Practice
Canadian Psychiatric Association Journal,
Vol. 8, No. 2, April 1963.

5. Myers, Evelyn S. - Insurance Coverage of Mental Illness 1962.
Joint Information Service,
Publications Department,
American Psychiatric Association,
1700 - 18th Street N.W.,
WASHINGTON 9, D. C.